|  |
| --- |
| **The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.**  **This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-565-9140 (TTY: 1-800-848-0299) or visit us at www.bcbst.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at [www.cciio.cms.gov](http://www.cciio.cms.gov) or call 1-800-565-9140 to request a copy. |

| **Important Questions** | **Answers** | **Why This Matters:** |
| --- | --- | --- |
| **What is the overall deductible?** | In-network: $800 person/$2,400 family  Out-of-network: $1,600 person/$4,800 family | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. |
| **Are there services covered before you meet your deductible?** | Yes. Preventive services, Office visits, and Emergency room visits are covered before you meet your deductible (unless specified). | This plan covers some items and services even if you haven’t yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at <https://www.healthcare.gov/coverage/preventive-care-benefits/>. |
| **Are there other**  **deductibles for specific services?** | No. | You don’t have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | In-network: $3,200 person/$9,600 family  Out-of-network: $6,400 person/$19,200 family | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| **What is not included in**  **the out-of-pocket limit?** | Premium, balance-billing charges, penalties, and health care this plan doesn't cover. | Even though you pay these expenses, they don’t count toward the out–of–pocket limit. |
| **Will you pay less if you use a network provider?** | Yes. This plan uses Network P. See www.bcbst.com or call 1-800-565-9140 for a list of in-network providers. | This plan uses a provider network. You will pay less if you use a provider in the plan’s network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider’s charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| **Do you need a referral to see a specialist?** | No. | You can see the specialist you choose without a referral. |

|  | All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies. |
| --- | --- |

| **Common  Medical Event** | **Services You May Need** | **What You Will Pay** | |  | **Limitations, Exceptions, & Other Important Information** |
| --- | --- | --- | --- | --- | --- |
| **In-Network Provider**  **(You will pay the least)** | **Out-of-Network Provider**  **(You will pay the most)** | |
| **If you visit a health care provider’s office or clinic** | Primary care visit to treat an injury or illness | $25 copay/visit deductible does not apply. | 40% coinsurance | | PhysicianNow - Powered by MDLIVE: $25 copay |
| Specialist visit | $45 copay/visit deductible does not apply. | 40% coinsurance | | Office surgery subject to Office Copay. |
| Preventive care/screening/  immunization | No Charge | 40% coinsurance | | A1c testing will be covered at 100%. You may have to pay for services that aren’t preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. Travel immunization not covered in office or clinic setting. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 20% coinsurance | 40% coinsurance | | None |
| Imaging (CT/PET scans, MRIs) | 20% coinsurance | 40% coinsurance | | Prior Authorization required. Your cost share may increase to 50% if not obtained. |
| **If you need drugs to treat your illness or condition**  More information about **prescription drug coverage** is available with your Pharmacy Carrier | Generic drugs | Copay/prescription:  $15 (retail), $45 (mail  order) | N/A | | Covers 30 day supply (retail), 31-90 day supply (mail order). Includes contraceptive drugs & devices obtainable from a pharmacy, oral fertility drugs. No charge for formulary generic FDA-approved women's contraceptives in-network. |
| Preferred brand drugs | $40 copay (retail)  $120 copay (mail order) | N/A | | Review your formulary for prescriptions requiring precertification or step therapy for coverage. Your cost will be higher for choosing Brand over Generics. Maintenance drugs - no refill restrictions or penalties apply. Members save with lower copays with OptumRx Home Delivery. |
| Non-preferred brand drugs | $400 or 75% with $400 minimum | N/A | | None |
| Specialty drugs | $15 Copay Generic ; $400 or 75% with $400 minimum | N/A | | Must be filled through BriovaRx Specialty Pharmacy. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | 40% coinsurance | | Prior Authorization required for certain outpatient procedures. Your cost share may increase to 50% if not obtained. |
| Physician/surgeon fees | 20% coinsurance | 40% coinsurance | | Prior Authorization required for certain outpatient procedures. Your cost share may increase to 50% if not obtained. |
| **If you need immediate medical attention** | Emergency room care | $300 copay/visit then 20% coinsurance. | $300 copay/visit then 20% coinsurance. | | Deductible applies |
| Emergency medical transportation | 20% coinsurance | 20% coinsurance | | None |
| Urgent care | $25 copay deductible does not apply. | 40% coinsurance | | Office surgery subject to Office Copay. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance | 40% coinsurance | | Prior Authorization required. Your cost share may increase to 50% if not obtained. |
| Physician/surgeon fees | 20% coinsurance | 40% coinsurance | | Prior Authorization required. Your cost share may increase to 50% if not obtained. |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $25 copay/visit deductible does not apply for office visits and 20% coinsurance other outpatient services | 40% coinsurance | | Prior Authorization required for electro-convulsive therapy (ECT). Your cost share may increase to 50% if not obtained. |
| Inpatient services | 20% coinsurance | 40% coinsurance | | Prior Authorization required. Your cost share may increase to 50% if not obtained. |
| **If you are pregnant** | Office visits | $25 copay/visit deductible does not apply. | 40% coinsurance | | Copay applies to initial visit to determine pregnancy. |
| Childbirth/delivery professional services | 20% coinsurance | 40% coinsurance | | None |
| Childbirth/delivery facility services | 20% coinsurance | 40% coinsurance | | None |
| **If you need help recovering or have other special health needs** | Home health care | 20% coinsurance | 40% coinsurance | | Limited to 40 visits per year. |
| Rehabilitation services | 20% coinsurance | 40% coinsurance | | Physical, Speech and Occupational Therapy limited to 20 visits combined per year. Cardiac/Pulmonary Rehab visits limited to 36 per type per year. Manipulative limited to 20 per year. |
| Habilitation services | 20% coinsurance | 40% coinsurance | |
| Skilled nursing care | 20% coinsurance | 40% coinsurance | | Skilled nursing and rehabilitation facility limited to 60 days combined per year. |
| Durable medical equipment | 20% coinsurance | 40% coinsurance | | Prior Authorization may be required for certain durable medical equipment. Your cost share may increase to 50% if not obtained. |
| Hospice services | 20% coinsurance | 40% coinsurance | | Prior Authorization required for inpatient hospice. Your cost share may increase to 50% if not obtained. |
| **If your child needs dental or eye care** | Children’s eye exam | Not Covered | Not Covered | | None |
| Children’s glasses | Not Covered | Not Covered | | None |
| Children’s dental check-up | Not Covered | Not Covered | | None |

**Excluded Services & Other Covered Services:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)** | | |  |  |
| * Bariatric surgery * Cosmetic surgery * Dental care (Adult / Children) * Hearing aids for adults | * Hearing aids for children under 18 * Infertility treatment * Long-term care * Prescription Drugs | * Private-duty nursing * Routine eye care (Adult / Children) * Routine foot care for non-diabetics * Weight loss programs | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.)** | | |  |  |
| * Acupuncture | * Chiropractic care | * Non-emergency care when traveling outside the U.S. | | |

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is:

* For plans subject to ERISA, the U.S. Department of Labor’s Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).
* For non-federal governmental plans, the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).
* For church plans, the State Division of Benefits Administration at 1-866-576-0029.
* BlueCross at 1-800-565-9140 or [www.bcbst.com](http://www.bcbst.com), or contact your plan administrator.

Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

* BlueCross at 1-800-565-9140 or [www.bcbst.com](http://www.bcbst.com), or your plan administrator.
* For plans subject to ERISA, the U.S. Department of Labor’s Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).
* The State Division of Benefits Administration at 1-866-576-0029.

Additionally, a consumer assistance program can help you file your appeal. Contact the Tennessee Department of Commerce and Insurance (TDCI) at 1-800-342-4029, <https://sbs-tn.naic.org/Lion-Web/servlet/org.naic.sbs.ext.onlineComplaint.OnlineComplaintCtrl?spanishVersion=N>, or email them at [CIS.Complaints@state.tn.us](mailto:CIS.Complaints@state.tn.us). You may also write them at 500 James Robertson Pkwy, Davy Crockett Tower, 6th Floor, Nashville, TN 37243.

**Does this plan provide Minimum Essential Coverage? YES**

If you don’t have Minimum Essential Coverage for a month, you’ll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**Does this plan meet Minimum Value Standards? YES**

If your plan doesn’t meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

––––––––––––––––––––––*To see examples of how this plan might cover costs for a sample medical situation, see the next section.–––––––––––*–––––––––––



**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

**About these Coverage Examples:**

**Peg is Having a Baby**(9 months of in-network pre-natal care and a hospital delivery)

◼ **The plan’s overall deductible** **$800**

◼ **Specialist copay $45**

◼ **Hospital (facility) coinsurance 20%**

◼ **Other** **coinsurance 20%**

**This EXAMPLE event includes services like:**

Specialist office visits (*prenatal care)*

Childbirth/Delivery Professional Services

Childbirth/Delivery Facility Services

Diagnostic tests (*ultrasounds and blood work)*

Specialist visit *(anesthesia)*

|  |  |
| --- | --- |
| **Total Example Cost** | **$12,700** |

**In this example, Peg would pay:**

|  |  |
| --- | --- |
| *Cost Sharing* | |
| Deductibles | $800 |
| Copayments | $0 |
| Coinsurance | $2,200 |
| *What isn’t covered* | |
| Limits or exclusions | $100 |
| **The total Peg would pay is** | **$3,100** |

**Managing Joe’s type 2 Diabetes**(a year of routine in-network care of a well-controlled condition)

◼ **The plan’s overall deductible** **$800**

◼ **Specialist copay $45**

◼ **Hospital (facility) coinsurance 20%**

◼ **Other** **coinsurance 20%**

**This EXAMPLE event includes services like:**

Primary care physician office visits (*including disease education)*

Diagnostic tests *(blood work)*

Prescription drugs

Durable medical equipment *(glucose meter)*

|  |  |
| --- | --- |
| **Total Example Cost** | **$7,400** |

**In this example, Joe would pay:**

|  |  |
| --- | --- |
| *Cost Sharing* | |
| Deductibles | $800 |
| Copayments | $100 |
| Coinsurance | $900 |
| *What isn’t covered* | |
| Limits or exclusions | $600 |
| **The total Joe would pay is** | **$2,400** |

**Mia’s Simple Fracture**(in-network emergency room visit and follow up care)

◼ **The plan’s overall deductible** **$800**

◼ **Specialist copay $45**

◼ **Hospital (facility) coinsurance 20%**

◼ **Other** **coinsurance 20%**

**This EXAMPLE event includes services like:**

Emergency room care *(including medical supplies)*

Diagnostic test *(x-ray)*

Durable medical equipment *(crutches)*

Rehabilitation services *(physical therapy)*

|  |  |
| --- | --- |
| **Total Example Cost** | **$1,900** |

**In this example, Mia would pay:**

|  |  |
| --- | --- |
| *Cost Sharing* | |
| Deductibles | $800 |
| Copayments | $700 |
| Coinsurance | $50 |
| *What isn’t covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,550** |

**Nondiscrimination Notice**

BlueCross BlueShield of Tennessee (BlueCross) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. BlueCross does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

BlueCross:

* Provides free aids and services to people with disabilities to communicate effectively with us, such as: (1) qualified interpreters and (2) written information in other formats, such as large print, audio and accessible electronic formats.
* Provides free language services to people whose primary language is not English, such as: (1) qualified interpreters and (2) written information in other languages.

If you need these services, contact a consumer advisor at the number on the back of your Member ID card or call 1-800-565-9140 (TTY: 1-800-848-0298 or 711).

If you believe that BlueCross has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance (“Nondiscrimination Grievance”). For help with preparing and submitting your Nondiscrimination Grievance, contact a consumer advisor at the number on the back of your Member ID card or call 1-800-565-9140 (TTY: 1-800-848-0298 or 711). They can provide you with the appropriate form to use in submitting a Nondiscrimination Grievance. You can file a Nondiscrimination Grievance in person or by mail, fax or email. Address your Nondiscrimination Grievance to: Nondiscrimination Compliance Coordinator; c/o Manager, Operations, Member Benefits Administration; 1 Cameron Hill Circle, Suite 0019, Chattanooga, TN 37402-0019; (423) 591-9208 (fax); [Nondiscrimination\_OfficeGM@bcbst.com](mailto:Nondiscrimination_OfficeGM@bcbst.com) (email).

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at [*https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*](https://ocrportal.hhs.gov/ocr/portal/lobby.jsf)*,* or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1–800–368–1019, 800–537–7697 (TDD). Complaint forms are available at [*http://www.hhs.gov/ocr/office/file/index.html*](http://www.hhs.gov/ocr/office/file/index.html)*.*

